Care of orphans in traditional foster homes (extended family care) in Lusaka district.

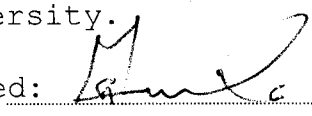
Dr Felix Silwimba. mbchb.

A dissertation submitted to the university of Zambia in partial fulfilment of the requirements for the award of masters of public health (MPH)

University of Zambia
School of Medicine.
Department of Community Medicine
Lusaka.
May 2006

Declaration

This dissertation is the original work of Felix Silwimba. It has been prepared in accordance with the guidelines for MPH dissertations of the University of Zambia. It has not been submitted elsewhere for a degree at this or another university.

Signed: 

Date: 31st May 2006

CERTIFICATE OF COMPLETION OF DISSERTATION

I Felix Silwimba hereby certify that this dissertation is the product of my own work and, in submitting it for my MPH programme, further attest that it has not been submitted in part or in whole to another university.

Signature: .....
Date 31st May 2006

I/we.....

having supervised and read this dissertation, am/are satisfied that this is the original work of the author under whose name it is being presented. I/we confirm that the work has been completed satisfactorily and is ready for presentation to the examiners.

Signature/Supervisor ..... Prof K S Babu

Date: 31/05/06

Chairman: ..... Dr Simuunza, G.B.

Date: 01.06.06

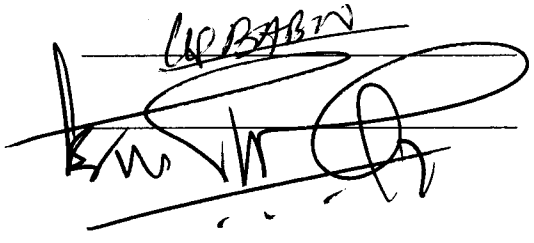
Department: .....

HEAD COMMUNITY MEDICINE
SCHOOL OF MEDICINE
UNIVERSITY OF ZAMBIA
P.O. BOX 50110, LUSAKA.

Approval

The University of Zambia approves this dissertation of Felix Silwimba in partial fulfillment for the requirements for the award of the degree in master of public health

Examiner's Signature



Date

31/05/06

01/06/2006

Abstract.

Objective: To determine the extent to which orphans and foster parents know and make use of services aimed at mitigating the impact of HIV/AIDS related orphanhood.

Design: This was a population study involving randomly selected households with orphans in Kabwata constituency.

Setting: the study was carried out in Kabwata health centre catchment area, which is a part of the Kabwata constituency. This area is a council planned settlement with sanitation, water, telephone and road infrastructure in place. The area is estimated to have a population of 71,722 of which the population below 15 years old was 8,607. (Kabwata Health centre HMIS 2005)

Methodology: Research assistants using a structured questionnaire, randomly recorded interviews with 380 households and 662 orphans.

In this study only those households with orphans were interviewed upon obtaining consent and assent from them. Those who refused were not included in the study.

Main objective of the study:

The main objective of the study was to look at the use of support and care groups by households with orphans, and whether the heads of households were aware of government

policies on orphans and who in the community actually took care of them.

Results:

The study showed that 98.5% (370) of heads of households did not make use of care and support groups, 63.7% (235) of orphans were in the care of single women and 67.7% were in the care of widows. Over two-thirds (117) of the heads of households earned less than US $100 per month. The fact that single women and widows cared for orphans signified the magnitude of the problem.

Double orphans were 34% (223) and single orphans 66% (439). 84% (409) of the orphans walked to school. The remaining parent cared for over 82% (358) of the single orphans. 96% (364) of the orphans did not receive any care and support from the care and support groups! Major help received was food and some funding to assist the orphans for primary school.

The area being a planned settlement with most residents being considered middle class was overlooked by most care and support groups. Major causes of death of the parents of the orphans were HIV, chronic illness and tuberculosis; together they constituted about 70%(252). If these children were tested, HIV infection could be a common feature among them.

Conclusions

Of the 380 heads of households 66% (251) were single parents with an average of 2 orphans each. 20% of these (76) were above the age of 50. 80% (301) of the orphans fell between the ages 6 to 14 years of the age. 67% (446) have not yet acquired education beyond grade 9. Data clearly demonstrates most of the parents of the orphans were infected with HIV infection. Suspicion of transmission of HIV to these children could also be high in their offspring. Finally most of the parents coming from peri-urban low socio-economic background were not aware of the support services nor did they make use of them.

Recommendations

There is urgent need to revisit the efficacy of the care and support services for the orphans. If these were successful the plight of the foster parents would be less and the future of the orphans would be bright. Identification of HIV is an important issue if one intends to reduce the number of orphans in Zambia, which is likely to be about 2 million by the year 2010. Voluntary counselling and testing care and support services including prevention of mother to child transmission must be strengthened, without which the future of orphans looks uncertain. It was hoped that with help of support services the foster homes would give better care to

Acknowledgements

I'm extremely thankful to Professor K.S. Baboo for his tireless contribution to the development of this thesis from questionnaire design, identification of the real problem of orphans and interpretation of date. His constructive criticisms were of great help.

Professor S. Siziya head of department showed extensive *leadership abilities to find time despite his busy schedules* to extensively contribute in putting the data of this thesis in its proper order and meaning.

I thank my sponsors USAID and the Ministry of Health headquarters for having arranged the scholarship and permitting me to undertake the masters in public health course.

I thank the Kasama District Management Board for the encouragement and support they given me throughout my studies. The Lusaka Urban District Management Team for the permission to conduct the study.

I thank the Kabwata Health Centre Management for the support. The four research assistants from the Neighbourhood Health Committee namely Mr Abel Ndhlovu, Mr Alex Zulu, Mr Richard Katutwa and Mr Andrew Sampa without whom data collection could have been impossible. I do thank the heads

of households and orphans who voluntary participated in this study.

Table of contents.

List of tables

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome.
ARV	Antiretroviral treatments.
CBO	Community Based Organisation.
CBoH	Central Board of Health.
CCUP	Child Care Upgrading Programme
CHIN	Children in Need.
CSCP	Child Social Care Project
DATF	District AIDS Task Force
FHI	Family Health International
HBC	Home Based Care
HIV	Human Immune Deficiency Virus.
LCMS	Living Conditions Monitoring Survey.
MOH	Ministry of Health.
NAC	National AIDS Council.
NCC	National Child Council
NGO	Non Governmental Organisation.
NSC-OVC	National Steering Committee on Orphans and Vulnerable Children.
PMTCT	Prevention of Mother to Child Transmission.
TB	Tuberculosis
UNCRC	United Nations Committee on the Rights of the Child.

UNICEF	United Nations Children's Emergency Fund.
UOA	Ukimwi Orphans Assistance
USAID	United States Agency for International Development.
VSU	Victim Support Unit.

Chapter one

Background information

There are 34.7 million children under age 15 in 34 countries who have lost their mother, father or both to HIV/AIDS and other causes of death, by 2010 that number will rise to 44 million. In 2010, 20 percent to 30 percent of all children under age 15 will be orphaned in 11 sub-Saharan African countries, -even if all new infections are prevented and some form of treatment is provided to slow the onset of AIDS in those infected with HIV.[5]

The HIV/AIDS pandemic has left an estimated 620,000 orphans in Zambia today. It is estimated that by the year 2010 Zambia will have a total of 1,328,000 orphans of which 936,167 orphans will be HIV/AIDS related. The estimates are further broken down into the type of orphans: maternal orphans will be 562,443, paternal orphans will be 598,652 and 166,905 will be dual orphans in 2010; of which HIV/AIDS will account for 403,647 maternal orphans, 379,427 paternal orphans and 153, 093 dual orphans[16] .

In addition to the problem of increasing orphaned are the declining incomes of families who are equally infected and affected by HIV/AIDS since they have to spend their meagre earnings in caring for the chronically ill adults and also

care for the needs of children.

The problem of Orphan care, which for now has remained a sole responsibility of the African extended family system. The effectiveness of this traditional method has been so good that it has prevented this big humanitarian issue from being an obvious problem in Zambia. However, the system needs to be monitored to ensure good practices in conformity with national aspirations for child development. This apparently is not the case.

We see a wide variety of care for orphans from those living in abject poverty to extreme riches. The consequences have given rise to vagabonds and juvenile delinquency and giving rise to vices as prostitution, drug abuse and other crimes.

Statement of the problem

The care for orphans still remains predominately a responsibility of the extended family. Unfortunately this support method is seriously weakened by the prevailing poverty levels in the Zambian population. There are policies, guidelines and programs on the protection of orphans and vulnerable children in Zambia. The extent to which these policies, guidelines and programs are known by those affected is not clear; neither do we know to what extent orphans and their foster parents make use of

available services meant to mitigate the impact of related orphanhood.

The question is; are orphans and foster parents making use of community based programs targeting care and support for related orphanhood?

Justification of the study

The literature found on orphanhood mostly dealt on quantifying the problem and expressed sentiments on the need for action to avert a looming disaster. However, there was no literature found on orphans and foster parents' use of services aimed at mitigating the impact of HIV/AIDS under care and support programs. It was therefore important to find out the extent to which orphans and foster parents in Kabwata constituency knew and made use of available services, in order to design strategies that would help improve community access to these services.

Hypothesis

Orphans and foster parents are not making use of community based programs targeting care and support under HIV/AIDS impact mitigation programs.

Research objectives

General objectives.

To determine the extent to which orphans and foster parents knew and made use of services aimed at mitigating the impact of HIV/AIDS related orphan hood so as to design interventions to increase access to these services.

Specific objectives.

1) To determine the awareness among foster parents of educational, health and psychosocial services available for orphans in the community.
2) To determine community based service providers reaching orphans and their foster parents under care and support.
3) To determine the proportion of orphans and foster parents accessing the existing community-based programs providing orphan support.
4) Explore reasons why some orphans and foster parents may not access the HIV/AIDS impact mitigating programs.

Operational definitions

Orphan, in the living conditions monitoring survey (LCMS of Zambia) an orphan is defined as a person aged 20 years or less who had lost at least one parent. The age 20 was used as the last age in this category because after that, one is expected to fend for oneself.[17]

Orphans are defined as **maternal** (loss of mother), **paternal** (loss of father) or **double** or **dual** (loss of both parents) of a child aged under 15 years.[7] These was the working definition for this research.

Head of Household: this refers to a person who makes day-to-day decisions concerning the running of the household and is also regarded as such by all household members.[20]

Household: a group of persons who normally live and eat together. These people may not be biologically related to each other and make common provision for food and other essentials for living.[20]

African children live in both "households" and "families". A household can be defined as a group of people, living together, who are usually economically independent.[4]

Families in traditional societies typically involve a much larger network of connections among people, enveloping the household in relationships that include multiple generations, extend over a wide geographical area and are based upon reciprocal rights and duties.[4]

The term **"extended family"** places special emphasis on the role of relatives outside the household in providing *economic and social support to survivors from AIDS* - affected homes -extended family the traditional social security system.[4]

Chapter two

Literature Review

MOH/CBoH estimated that by the end of year 2000, more than 500000 children would have lost their mothers or both parents due to AIDS. By the year 2010, it is projected that the number of orphans will exceed one million[12]. Family Health International (FHI) (July 2002) estimated that there were 850 000 orphaned children in Zambia with a prediction that this number will rise to nearly two million by the year 2010 and also that in the year 2000 nearly 76.3 percent of all orphaned children had resulted from the pandemic[5]. The AIDS epidemic is the major factor contributing to orphanhood, in 1996 about 93 percent of all orphans lived with family members or neighbours, about 6 percent lived in the streets and less than one percent lived in orphanages.[19]

The care of orphans has mainly remained the primary responsibility of the extended family and the neighbours, which is a community-based response. If not supported this responsibility will overstretch the resources of those providing foster care for the orphans and push them and their families into further poverty and compromise the care

of the orphans. The care provided by the extended family has been so effective that it has prevented the big problem of orphans being obviously visible.[4]

The pandemic with its associated deaths is rapidly weakening this social security method that now orphans are visible than before. The care and support is taking centre stage as a strategy in mitigation initiatives of the impact of HIV/AIDS related orphanhood in sub Sahara Africa .For instance on September 9th to 10th, 2002 a group of prominent individuals gathered in Johannesburg, South Africa, their goal was to come up with a set of concrete actions that would ensure a quantum shift in the global response to children affected by HIV/AIDS related deaths of parents. Nelson Mandela and Graça Michel convened the meeting.[26]

The following are further estimates of the magnitude of the problem from various sources, around the world 8 million children by 1998 had lost their mothers and often their fathers before they were 15 years.[29] Today some three million children are living with HIV infection and the population of children orphaned by AIDS stands at over 13 million and will top 25 million by the year 2010. The vast majority of these children and young people live in sub Saharan Africa.[26]

The national demographic and health survey (DHS) 2001-2002 reports that children in difficult situation 16.2 percent at least one parent had died and three percent both parents had died.[19]

UNICEF estimated that in 1990, fewer than one million sub Saharan southern Africa children under the age of 15 had lost one or both parents to HIV /AIDS. At the end of 2001, 11 million in this age group were orphans because of HIV/AIDS, nearly 80 percent of the world total. By 2010, 20 million in this age group are likely to be orphans from this single cause.[21] Estimates from the year 2000 indicate that nearly 76.3% of all orphaned children have resulted from the HIV/AIDS pandemic.

One measure of the massive social change yet to come as a result of the global pandemic is the number of orphans, children affected by HIV/AIDS, and other vulnerable children. According to revised 2000 estimates, there are 34.7 million children under age 15 in 34 countries who have lost their mother, father, or both parents to HIV/AIDS and other causes of death. By 2010 that number will rise to 44 million. Without AIDS, the total number of children orphaned would have declined by 2010 to fewer than 15 million. In 2010, 20 percent to 30 percent of all children

under age 15 will be orphaned in 11 sub-Saharan African countries-even if all new infections are prevented and some form of treatment is provided to slow the onset of AIDS in those infected with HIV.[5]

UNICEF estimates that Zambia has 650000 orphans below the age of 15. One of About 16 percent of the population aged 20 years and below, where orphans in 1998 this amounted to just over 900000 orphans[13].

The figures quoted above from various sources underscore the magnitude of the orphanhood problem.

Foster (1997) observed that AIDS had already led to widespread and marked reductions in life expectancy, with life expectancy for females being lower than that for males because women are infected with HIV and die at younger ages than men; lower life expectancy lead to an increase in the proportion of orphaned children. It is likely that at least 30 million children are living with HIV-positive parents, at risk of being orphaned in the next few years.[2] The Zambia demographic health survey (2001-2002) show that fathers of 12 percent of the children under the age of 15 are dead, mothers of six percent are dead and both parents of three percent are dead[19].

Foster (1997) stated that the level of orphanhood would increase as HIV spreads and the prevalence of AIDS raised.[3]

Goncalves (1994) documented an extreme example of a Uganda grandmother who had lost six children to AIDS and cared for her 25 grand children. He further commented that consequences were far reaching, there were the cost of funerals, which many poor could not afford; the orphans, lack of caretakers or overwhelmed caretakers, loss of productive workers, and drains on health services.[6]

UNICEF's Eastern and South Africa region priority for its programming is to care and provide support for children orphaned by HIV/AIDS and one area of care is foster care.[26]

The loss of a father was the most common form of orphanhood at all ages, in all strata and in every province.[18] The main problems orphans faced were lack of school fees, food and access to medical care.[17]

It was observed that in the age group 7-14 years the proportion of girls attending school was equal to that of boys. While in the age group 14 - 18 the proportion of girls attending school was lower than that of boys by a high margin[18]. School completion rates for girls are between 10 to 15 percent below those of boys, thus making them vulnerable to STD/HIV infection. The orphaned girl

child is more likely to drop out of school. There is potential that the vulnerable children, many of them teenagers, are also at risk for sexually transmitted diseases, including HIV/AIDS, as their precarious economic situation out of school exposes them to sexual exploitation.[17]

Madhavan and Sangeetha (2004) noted that of particular concern were the points of continuity and change in fosterage patterns before and after the onset of the epidemic in South Africa. They suggested that an understanding of the short and long term consequences for children orphaned by AIDS in South Africa called for historical contextualisation given that child fostering, both voluntarily and involuntarily, had been a feature of black family life since well before the onset of HIV/AIDS. In addition demonstrated the value of kinship, family and networks in order to fully understand the circumstances of fostering these children.[11]

Bostock and Lisa reviewed research on child minding registration to assess whether a similar system would regulate private fostering arrangements and thereby protect a hitherto neglected group of vulnerable children, private foster children.[1]

Wines and Michael (2003) reported the rise in the number of African children who have lost at least one parent to AIDS according to the United Nations Children's Fund. Percentage of children that are likely to become AIDS orphan; implications for generations of orphans in sub-Sahara Africa; efforts of the organisation to urge governments and relief organisations to try to head off the most damaging impact of an orphan population.[30]

Rutayuga (1997) observed that the Ukimwi Orphans Assistance (UOA) had found that culture-based programs succeeded because they offered guarantees of sustainability and cost-effectiveness. African principles of kinship and the extended family are used to develop resources for providing minimum assistance and to rebuild caring and supporting communities for the children. They concluded that determined community efforts should be an incentive for increased external aid.[23]

Roys, (1995) reported on the child social care project (CSCP) in Ugandan districts how it helped to ensure that orphaned children under 18 years who have lost one or both parents to AIDS received the property rights to which they are entitled.[22]

The United Nations Committee on the Rights of the Child 33rd

session 2003 studied the Zambian report on the child under article 44 of the convention and made the following observations about Zambian orphans[28]. That a large number of families were headed by single parents, mostly women and / or AIDS orphans, many of them faced financial and other kinds of difficulties which negatively affected the upbringing and development of the child. That there was lack of involvement of fathers in the upbringing and development of children.

The committee noted the information that children deprived of family environment (orphans and other vulnerable children) were to be cared for by the extended family and that foster care was to be supported by special fees for foster parents, but the committee was concerned that these forms of alternative care were not sufficiently encouraged and supported.

They noted the existence of the Child Care Upgrading Programme (CCUP) but was concerned, inter alia in light of the increasing number of AIDS orphans, that a growing number of children was being placed in institutions and that there was a lack of disaggregated data in this regard, which made it difficult to fully assess the need for institutional care and to develop effective policies. The

committee also noted with concern the absence of an independent complaint mechanism for children in alternative care institutions, the inadequate review of their placement in institutions as well as the lack of available trained personnel in this field.

The committee noted that the adoption act of 1958 provides for the regulation of adoptions (domestic and inter-country), but remains concerned that informal adoptions, which are generally not monitored with respect to the best interests and other rights of the child, are more widely accepted and practised within the state party.

They noted the existence of the National Steering Committee on Orphans And Vulnerable Children and the recent adoption of the National HIV/AIDS/STI/TB council Act no.10 of 2002 but remained extremely concerned at the high incidence and increasing prevalence of HIV/AIDS amongst adults and children and the resulting high and increasing number of children orphaned by HIV/AIDS. In this regard, the committee was concerned at the insufficiency of alternative care for these children.

The popular solution to care for orphans has been Long-term institutionalization of children in orphanages and other facilities, this method works well for easy accountability

to the sponsors and media coverage of personalities who make generous contributions. Unfortunately these are to the socio-psychological detriment of the orphaned child. Resources expended to fund institutional care for a single child can assist scores of children if used effectively to support a community-based initiative. The institutionalization of children separates them from families and communities and often delays healthy childhood development.[4]

The responses being advocated for of late are those aimed at strengthening the care and coping capacities of families and communities: The first line of response to the needs of children affected by HIV/AIDS comes from extended families. Strengthening the capacity of communities to fill the widening gaps in the safety net traditionally provided by the extended family may be the most efficient, cost-effective, and sustainable way of assisting orphans and other vulnerable children. Families and communities also play a crucial role in identifying children who are most in need, both those affected by HIV/AIDS and other vulnerable children.

Since the problems experienced by orphans and other vulnerable children begin well before the death of their parents, care for children affected by HIV/AIDS should

start at the earliest possible point. Services for orphans and other vulnerable children should be integrated with the elements of comprehensive care such as voluntary counseling and testing for HIV, prevention of mother-to-child-transmission of HIV, and others.[4]

Silomba (2002) concluded that externally supported programs are needed that seek to alleviate the suffering of the orphans, vulnerable children, and Persons living with HIV/AIDS. However, what should not be ignored was the inherent capacity for care that exists in the neighbourhood and communities.[24]

Orphans and other vulnerable children are themselves at high risk of HIV infection due to economic hardships and loss of parental care and protection. For this reason alone, care programs should include a strong prevention component targeting children and youth.

In Zambia, more than one quarter of all children under 15 are already orphaned, and an estimated two-thirds of rural households already look after one or more orphaned children. To be in household containing orphans has become the norm, not the exception.[8]

In most parts of rural Zambia, grandparents are left to care for the young, and there is tremendous strain on the

extended families and the social system to provide the orphans with the needed care, resources, and supervision. Consequently, many of the orphans of school age do not attend school; do not have access to health care, as their guardians cannot raise school fees and other requisites. A large number of primary school dropouts and leavers are assuming adult family responsibilities.[13]

Those who stayed with grandparents are more vulnerable because a large proportion of caretakers who are elderly who neither have skills nor the jobs to enable them earn some income to support the orphans. For female orphans, the only `viable' alternative is commercial sex.[13]

Whereas, the primary focus of clinicians, researchers and service organisations has been on people who are ill and dying, the first concern of public health officials has been to prevent HIV transmission. Clinicians, researchers and service organisations do not consider the human and community aspects of the epidemic in terms of the fact that Children suffer from the social, economic and psychological consequences of the epidemic several years prior to the death of a parent as they live with prolonged or recurrent parental illness, Uncles and aunts form the first line of defence for a vulnerable child. Which is later moved to

grandparents or other relatives and almost always women, when the uncles and aunties become vulnerable too.[4]

Even though a family may not have sufficient resources to care for existing members, orphans are taken in. This has been the basis for the assertion that traditionally, "there is no such thing as an orphan in Africa" [4].

Helen raised the problematic issue of whether fostering and adoptive parents have the right to demand an HIV test on the child and the obligation to undergo an HIV test themselves.[9]

Helen concluded that taking the potential risks and benefits of community care, fostering and adoption and institutional care, the balance is undeniably in favour of supporting community care for the great majority of children, with formal fostering and adoption is a limited back -up strategy whilst institutional care essentially remains the last resort for a tiny minority, if all else fails.[10]

About 80% of the Zambian population living in poverty further exasperates the socio-economic well-being of Zambian families.[5]

Having a situation where most of the caregivers were female is an indication that most of the households were very poor

and unable to provide for the educational and health needs of the orphans. In the 1998 Zambian Living Conditions Monitoring Survey (LCMS) it was observed that most orphans who had lost the father, where in the very poor category[18].

Chapter three

Methodology

Study design and Methods.

This was a cross-sectional descriptive population study involving 380 randomly selected households with orphans in Kabwata constituency. The main data collection tool was a structured questionnaire for the head of the household and the orphan respectively.

Rationale;

The rationale for picking on the area was that the 199 CBOH and 2000 National AIDS council reports showed high number of orphans coming from the area, the households were mapped and institutions providing care and support were present in the area.

Limitations;

The Department of Community Medicine has the largest number of postgraduate students (25), in the University of Zambia, seeking ethical clearance from the Research ethics committee and the postgraduate studies committee. Therefore, getting ethical clearance and approval was one of the biggest problems since it took 15 to 20 weeks. These forced the researcher to carry out a convenient sample

rather than randomize all the households in the area that could have consumed more time and resources.

As a result a careful survey with the help of the Neighbourhood Health Committee was done.

Duration and place.

The study was conducted from the month of July to September 2004 in Kabwata constituency of Lusaka district.

Sample

The study population was composed of 380 randomly selected households from Kabwata, Kabwata estates, Kabwata Site and Service, Kamwala, Kamwala South, Libala and Chilenje. This areas falls within the catchment of Kabwata constituency. From within these households, 662 orphans were interviewed.

Sampling method:

As mentioned earlier with the help of the Neighbourhood Health Committee, care was taken to identify all the households who had orphans. This resulted in identifying 380 households with 662 orphans. This was most convenient as against any other epidemiological method, which could have required more time and resources.

Data management and analysis.

On a daily basis filled questionnaires from the four research assistants were reviewed and checked for completion and consistency. Those noted to be incomplete or inconsistent were returned to a particular research assistant for revisits and corrections. The questionnaires were developed in Epidata program. Through the Epidata program, data was cleaned and with epiInfo6 version 6.04 data was further cleaned for inconsistencies and was then ready for analysis.

Frequency tables were generated for all the variables. In certain variables, tables function were utilised. The unit of analysis was the household. The dependent variables were knowledge and use of services.

Pilot study.

A pilot study was conducted in the Lusaka central constituency; 20 households were interviewed. These allowed for the instruments to be checked on its suitability and minor amendments done.

Ethical considerations.

Permission was obtained from the research and ethics committee of the University of Zambia School of medicine, from the graduates studies committee of the university of Zambia and the Lusaka District Health Board.

Chapter Four.

Findings.

The data has been analysed based on responses from the heads of households and orphans.

Analysis of head of household questionnaire responses;

The heads of household interviewed had an age distribution of 20 to 66 years old, the youngest being 20, the oldest being 66, the average age being 40 and the most frequent age being 29 years old.

Table 1

Age group and sex distribution of head of households.

	Age group	Males		Females		total		
		N	Percent	n	Percent	n	percent	
	20 - 29	13	3.4	37	9.7	50	13.2	
	30 - 39	57	15	97	25.5	154	40.5	
	40 - 49	34	8.9	66	17.4	100	26.3	
	50 - 59	28	7.4	33	8.7	61	16.1	
	60 - 69	6	1.6	9	2.4	15	3.9	
		138	36.3	242	63.7	380	100	

The table shows that in the age group 30 to 39 and 40 to 49, female heads of households provided care for orphans 25.5% and 17.4% respectively. More female heads of households 63.7% took care of orphans.

Table 2

Status of employment and income category for the head of household.

Income group X1000	Employer	Employee	Self employed	Unpaid house worker	Retired	Total	Percent
50-250	0	16	34	3	1	54	30.0
+250-500	0	45	16	0	2	63	35.0
+500-1000	0	42	9	1	1	53	29.5
+1000-2000	1	4	1	0	0	6	3.3
>2000	0	1	3	0	0	4	2.2
Total	1	108	63	4	4	180	100

The table above shows that most incomes fell below one million Zambian Kwacha. This income is common among the employees, the self-employed and the retired. It is important to note that most heads of households were unwilling to state their incomes.

Table 3

Housewives Employment status and incomes.

Salary X1000	Skilled	Unskilled	Business	Total	Percent
50-250	3	1	1	5	23.8
+250-500	8	0	1	9	42.8
+500-1000	5	0	1	6	28.6
+1000-2000	0	0	1	1	4.8
Total	16	1	4	21	100

Majority of the housewives earned below K500,000 accumulative percent of 66.6%. (Note: by skilled jobs was

meant teacher, police officer, nurse, secretary etc.)

Money spent on orphans.

Heads of households estimated how much they spent on orphans. It was found out that the minimum was K30,000 and the most frequent expenditure was a K100,000 per month. However, an expenditure of K3,500,000 was mentioned which is an exception to the rule.

All heads of households responded that they provided everything for orphans in terms of food, shelter, clothing, education, healthcare like any other child. Again, this is not a realistic answer as elsewhere heads of households have failed to provide school fees.

Table 4

Marital status for the heads of households.

	Status	males		females		totals	
		n	percent	n	percent	n	percent
1	Married	80	21.0	38	10	118	31.0
2	Single	48	12.6	187	49.2	235	61.8
3	Divorced	1	0.3	15	4.0	16	4.2
4	Remarried	9	2.4	2	0.5	11	3.0
	Total	138	36.3	242	63.7	380	100

Two thirds of those who took care of the orphans were single a good proportion were single women at 49.2 %. Most male heads of households were married 21%.

Remarried Widowers account for 9% compared to widows 0.5%.

Table 5

Single heads of households for both males and females.

	Status	Males		Females		totals	
		n	percent	n	percent	n	percent
1	Unmarried	4	1.7	28	11.9	32	13.6
2	Widow	0	0	159	67.7	159	67.7
3	Widower	44	18.7	0	0	44	18.7
		48	20.4	187	79.6	235	100

Two - thirds of single heads of households were widows thus signifying the magnitude of the problem of inadequate care for orphans.

Distribution of orphans per household.

At least a third of households had two orphans under their care.

Table 6

Cause of death of the parent/parents.

	Cause of death	n	percent
	HIV/AIDS	27	7.1
	Tuberculosis	116	30.5
	Chronic Diarrhoea	25	6.6
	Long Illness	84	22.1
	Malaria	42	11.1
	Meningitis	29	7.6
	Pneumonia	15	3.9
	Reproductive health related	9	2.4
	Accidents	33	8.7
		380	100

Tuberculosis accounted for one third of deaths of parents, followed by chronic illness, malaria, accidents and meningitis.

Support sought after by foster parents.

Ninety five percent (95%) of the heads of households indicated that they required both financial and material support. About ninety six percent (95.8%) of households did not make use of care and support groups.

Reasons for not making use of support and care services;

The heads of households who had not made use of care and support services, majority about seventy seven percent (76.8%) said the services were not available, sixteen percent (16.1) said they were capable of caring for the orphan, four percent complained that services were not good and three percent (2.9%) said service providers for orphans interfered with a personal matter.

Awareness of government policies and mitigating services for orphanhood related to HIV/AIDS deaths.

Most of the households (over 80%) were not aware of government policies, and care groups aimed at mitigating the impact of HIV/AIDS related orphanhood.

Analysis of responses to questionnaire administered to orphans;

Of 662 orphans interviewed, 294 were males and 368 females. 117 were aged under one year to five years and 545 were aged between 6 and 14 years of age.

The predominant age ranges from birth to 14 years with an average of 9.4 years. The age 14 years was most dominant.

Table 7

Distribution of orphans by age group and sex.

Age group	Males		Females		Total	Percent
	n	Percent	n	percent		
Under Five	50	42.7	67	57.3	117	17.7
6 - 14 years	244	44.8	301	55.2	545	82.3
Total	294	44.4	368	55.6	662	100

Preschool and school attendance;

Four hundred eighty (480) were in either preschool or regular school whilst 182 did not attend.

Table 8

Preschool and school attendance;

	Preschool	Grade 1 - 7	Grade 8 - 9	Not eligible for enrolment	Not in school	Total
Number	34	336	110	111	71	662
Percent	5.2	50.7	16.6	16.8	10.7	100

Preschool orphans are those attended nursery school. Orphans not in school were those 7 years or older who were not attending school. The 'not eligible for enrolment'

orphans were those 6 years old and below who were neither in 'preschool' nor 'in school'.

It was further observed that at age 14, 15 orphans were not in school; of these 10 were girls (66.7%). This demonstrates the vulnerability of girl orphans as they grow past adolescence.

Education for the orphans;

A total of 72 preschool and regular schools were attended by the orphans within and outside the catchments area . Majority of orphans (84.0%) walked to school; 7.4% used public transport, 6.1% were driven to school, 2.1% used a school bus provided by the school; 0.4% cycled.

Only 7.4 % required transport money to get to and from school.

Happiness with the family;

Ninety six percent (95.7 %) were happy with the foster families.

Change of school following death of a parent or parents;

Only 15.4 % experienced a change of school against 84.4% who remained in the same schools. Notably two orphans changed from government schools to community schools on the basis that community schools offered extra support to identified orphans.

Orphans desired occupation;

Of the 433 orphans who identified their future carriers 82.9 % identified professional careers. 3% identified pastoral work. These demonstrated the determination the orphans have for success in future.

Changed places of residence following orphanhood;

237 (35.8%) orphans responded that they had lived with another family before coming to live with the present family.

Of the 237 orphans only 171 orphans were able to give responses of were they had lived before. 67.9% came from within Lusaka city compounds and 32.1 % from all over Zambia.

Table 9

Head of household by type of orphan and surviving parent;

Head of household	Type of orphan				Surviving parent			
	Double		Single		Mother		Father	
	n	%	n	%	N	%	n	%
Father	0	0	100	23.0	0	0	100	74.7
Mother	0	0	258	59.0	258	85.1	0	0
Brother	17	7.5	4	0.9	3	1.0	1	0.7
Sister	16	7.1	4	0.9	2	0.7	2	1.5
Uncle paternal	59	26.5	10	2.3	7	2.3	3	2.2
Aunt paternal	16	7.1	5	1.1	3	1.0	2	1.5
Uncle maternal	13	5.7	4	0.9	3	1.0	1	0.7
Aunt maternal	29	12.9	11	2.5	3	1.0	8	6.0
Cousin paternal	1	0.4	0	0	0	0	0	0
Cousin maternal	9	4.0	0	0	0	0	0	0
Grandparents paternal	28	12.4	12	2.7	7	2.3	5	3.7
Grandparents maternal	36	16.0	23	5.3	11	3.6	12	9.0
Adopted	1	0.4	6	1.4	6	2.0	0	0
TOTAL	225 34%	100	437 66%	100	303 69%	100	134 31%	100

One third of orphans were double orphans, a quarter of the double orphans were cared for by an uncle from the father's side.

Single orphans were cared for by the remaining parent mother or father (85.1% and 74.7 %). In this situation vulnerability could be worse for those orphans whose surviving parent is the mother.

Community based organization supporting orphans

Just like in the "heads of household" analysis 97% of orphans had no support from care and support groups.

Of the 17 orphans who benefited from the support and care groups, 29% received educational support, 11.8 % health care, 17.6 % education and health support and 41.2 % were supported with food.

Access to safe water and sanitation

A good proportion of orphans had access to safe and clean water (92.9%) that is combining piped water and bore water.(CSO 2000)

Excreta Disposal

99.2 percent of orphans safely disposed off excreta.

All households had a safe method of refusal disposal

91.5% orphans had access to electricity for lighting

Meals in a day

Over 90% of orphans answered that they had at least three meals a day and 82.9 percent reported that the meals were adequate.

How many bedrooms had the house?

Most of the houses were either two or three bed-roomed houses (38.2% and 40.5%) respectively. Furthermore 73.4% orphans shared a bed with another family member, thus signifying overcrowding in the homes that is a measure of

poverty.

Table 10

Ill health or good health amongst orphans.

	Reported ill	Reported good health	total
0 - 5 years	23	134	157
6 - 14 years	14	491	505
Total	37	625	662

RR = (23/157)/(14/505)

=5

the 0-5 years orphans are 5 times more likely to fall ill than among the 6-14 years orphans.

It be safely concluded that ill health amongst orphans was more likely with the under fives.

Cause of ill health

The commonest causes of ill health were cough and fever 35% and 27% respectively.

Where did the orphan get treated?

Most of the orphans when ill were treated at either a government hospital or clinic 98.3%.

Chapter five

Discussion;

The study interviewed about 380 heads of households comprising 662 orphans aged from birth to 14 years of age. They were either double or single orphans. Relatives cared for all the 230 double orphans. Eighty five percent (358) of the single orphans were living with the remaining parent of whom 60% (258) were with the mother and 23%(100) were with the father. The rest 17% (74) were under care of relatives. Since care and support is predominantly by the extended family, remaining parent who took care of the single orphans may expose the latter to illness fatality if care is not given to them. Thus, there is a 17% of the single orphans now in the care of relatives that would increase.

The ZDHS (1996) reported that 93% of all orphans lived with family members or neighbours; about 6% lived on the streets and les than one percent lived in orphanages.[18] Foster (2002), observed that the care of orphans remained the primary responsibility of the extended family and neighbours, which was a community response. Therefore, the findings of this study are in agreement with other studies. This study showed that the cause of orphanhood was as a result of parents dying of illness 98% (338). Considering,

the current situation of the epidemic we could safely say that HIV/AIDS infection contributed to these deaths. This is further supported by ZDHS (2002) reports that 76.3% of all orphaned children resulted from the HIV/AIDS pandemic.

The study clearly demonstrated that households who cared for orphans already had children of their own who required support, but were not receiving any support from care and support groups. Unicef (2000) observed that to be in a household with at least an orphan is the rule and not the exception. Helen noted that if extended family care were left unsupported it would overstretch the resources of those providing foster care for the orphans pushing them and their families into further poverty whilst compromising the care of orphans. This is demonstrated to some extent by room space, which is being compromised in foster family where orphans have to share a bed with another family member. Although orphans claimed to have three meals, we cannot believe this to be true as it clearly contrasts with the majority of the foster parents need for financial and material support. The financial constraint is further exemplified as most orphans conveniently walked to and from school in order to reduce the family burden of expense for transport money.

Heads of households were not aware of any government

policies aimed at mitigating the social impact of orphanhood as a result of HIV/AIDS, such as education for orphans, healthcare for orphans and psychosocial counselling. Consequently, the needs of orphans were not being adequately addressed. Orphans in this study had difficulties in accessing education beyond primary school level. Orphans aged 6 years and above paid for medical care. Those under five years accessed free medical care like any other child of that age.

Illness amongst orphans requires special attention, as it could be the starting point for care of HIV/aids infection in children. These children are more likely to be HIV positive .NAC reports that 40% of children born to HIV positive mothers are likely to have HIV infection. The argument can be taken further to the provision of free antiretroviral drugs.

The heads of households had mentioned two main care groups: the Kabwata Home Based Care (KHBC) and Children in Need (CHIND) respectively. KHBC under the Catholic church program reaches most households. Its mandate is to care for the chronically ill and patients on tuberculosis treatment but not orphans. CHIND has a national character and is meant to provide for all children in need Nation-wide but it was observed, the organization has stringent criteria

for selection of orphans to support .A small group of heads of households mentioned the seventh day Adventist Church, who appear to have resource limitation. This reduced the support they offered by equally limiting it to a few , mostly, church members. It is an important finding that the groups are "on the ground and something is being done. the fact is that "care and support" is taking centre stage as a strategy in mitigation initiatives of the impact of HIV/AIDS related orphanhood in sub Sahara Africa. UNICEF, in its programmes has made "care and support" a priority for the support of children orphaned by HIV/AIDS, and, one area of care is foster care.[26] We note that only five percent of the households received 'care and support'. We definitely would like to see a 'quantum leap' in this indicator.

ZDHS (2002) reported that 80% of families were poverty stricken and came from poor socio-economic background. Nyambedha et.al (2003) noted that the main problems orphans faced were lack of school fees, food and access to medical care. The findings of Nyambedha et.al (2003) coincide with this study where 95% (361) of the heads of households indicated they required both financial and material support.

The main reason advanced for not making use of 'care and

support' groups was services were not available. Women caregivers, most of them single and widowed are in majority confirming the observation by UNCRC that a large number of families in Zambia were headed by single parents, mostly women and /or AIDS orphans, many of them faced financial and other kinds of difficulties which negatively affected the upbringing and development of the child.

The study has shown that the major cause of death of parents of orphans was HIV/AIDS-related illness. Where 89% (338) of them died of an infection including tuberculosis, malaria, meningitis and pneumonia. Only 7.1% (27) speculated that the cause of death could have been HIV/AIDS.

The role of psychosocial counselling for both orphans and the caregivers cannot be overemphasized as both of them are devastated by the deaths and uncertainty surrounding the pandemic. It is unfortunate that we still have very few psychosocial counsellors such that the service is non-existent.

Chapter six

Conclusion:

Orphans were to a large extent under the care of the extended family; even those under care of the remaining single parent were sooner or later to be under the care of other family members especially women. HIV/AIDS was found to be the major contributor to the deaths of parents .ARV therapy and PMTCT will delay the onset of orphanhood by prolonging the life of the parents and reducing the transmission of HIV infection to children born to HIV positive mothers. These health interventions will lead to improved quality of life if families are supported.

Foster families have to a greater extent overstretched their resources and need to be helped expeditiously. 'Care and support' groups need to extend their horizons and do more to reach more orphans and most families inorder to mitigate the problems orphans and most families face in accessing education beyond primary level, seeking health care and food security.

Finally, of the 350 heads of household 66% (251) were single parents with an average of 2 orphans each. Twenty percent (20%) of these (76) were above age of 50. eighty percent (80%) (529) of the orphans were aged 6 to 14 years of age. Sixty seven percent (67%) (446) have not yet

acquired education beyond grade 9.

The data clearly demonstrates that most of the parents of the orphans were infected with HIV.

Most of the foster parents coming from periurban low-socio-economic background were not aware of the support services, nor, did they make use of them.

Chapter seven

Recommendations;

There is urgent need to revisit the efficacy of the 'support and care' services for the orphans. If these were successful, the plight of the foster parents would be less and the future of the orphans would be brighter.

Identification of HIV is an important issue if one intends to reduce the number of orphans in Zambia, which is likely to be about 2 million by year 2010. Voluntary and support services must embark on these problems. Various government departments, voluntary organisations and research organisations must implement the following.

1. Orphans information system database be established.
2. The Ministry of Community Development and Social Services expedite the implementation of the K50000 (fifty thousand Kwacha) per orphan incentive to foster households.
3. Ministry of Education to provide free education for orphans beyond primary level.
4. ARV and OI's treatment to be made widely accessible.
5. PMTCT program to continue on a wider scale.
6. Communities to be actively involved in the care of orphans.
7. ARV programs for orphans to be expedited.

8. Research in the behavioural patterns of orphans especially the girl child at adolescence.

References:

1. Bostic, Lisa. Safeguarding the welfare of private foster children. Children and society, January 2004; 18 (1): 66-68.
2. Foster G. Africa's children and AIDS a continent in crisis the devastation of the HIV/AIDS pandemic. AIDS LINK May-June 1997; 45:4-5.
3. Foster G. deteriorating child health in countries with severe AIDS epidemics; forecasts and challenges. AIDS Annual Africa. October 1997; 7(5): 12-13.
4. Foster G. Understanding community Responses to the situation of children affected by AIDS; Lessons for external Agencies. (Sidastudies number 7 One step further -responses to HIV/AIDS -Editor Anne Sisask. Elanders Novum AB, Gothenburg 2002:91-112.
5. Family Health International. The impact of HIV/AIDS on lives of orphaned children and their guardians. July 2002:3.
6. Goncalves F. the scourge of HIV and AIDS in Africa. South Africa. Political Economic Monitor. June 1994; 7(9): 5-8.
7. Helen J. Children in Peril, the scale of orphanhood. AIDS AFRICA CONTINENT in crisis, SAFAIDS, Avondale,

Harare, Zimbabwe 2002; 9: 267.

8. Helen J. Children in Peril, the Problem. AIDS AFRICA CONTINENT in crisis, SAFAIDS, Avondale, Harare, Zimbabwe 2002; 9:268.
9. Helen J. Children in Peril, Community care. AIDS AFRICA CONTINENT in crisis, SAFAIDS, Avondale, Harare, Zimbabwe 2002; 9: 284.
10. Helen J. Children in Peril, Institutional care. AIDS AFRICA CONTINENT in crisis, SAFAIDS, Avondale, Harare, Zimbabwe 2002; 9:292.
11. Madhavan, Sangeetha. Fosterage patterns in the age of AIDS: continuity and Change. Social Science and Medicine; April 2004; 58(7): 1443.
12. Ministry of Health /Central Board of health, HIV/AIDS in Zambia, Background projections impacts, interventions. September 1999; orphans as a result of AIDS: 35-36.
13. National HIV/AIDS/STD/TB Council, Strategic framework 2001-2003, October 2000; 1.5.2:14.
14. National HIV/AIDS/STD/TB Council, Interventions on strategic plan 2002-2005, May 2003; Objective 6: 13.
15. National HIV/AIDS/STD/TB Council, Interventions on strategic plan 2002-2005, May 2003; 2.2.3(community): 19.

16. National HIV/AIDS/STD/TB Council, Joint review of the national HIV/AIDS/STI/TB intervention strategic plan (2002-2005) and operations of the National AIDS Council, June 2004 P 13,38.

17. Nyambedha E.O. Wandibba S, Aagaard-Hansen J. Changing patterns of orphans care due to the HIV epidemic western Kenya. Social Science and Medicine 2003; 57: 301-311.

18. Republic of Zambia, Central statistical office, Living Conditions in Zambia- 1998; 5.6: 28-29.

19. Republic of Zambia, Central Statistical Office, Zambia Demographic and Health Survey 2001-2002; February 2003; 2.3: 14.

20. Republic of Zambia, Central Statistical Office, Zambia 2000 Census of population and Housing, November 2003; Lusaka district: 29.

21. Republic of Zambia, Central Statistical Office, Zambia 2000 Census of population and Housing, Zambia Analytical Report Volume 10 November 2003; 3: 27-28.

22. Roy S. Widows and orphans' property disputes; the impact of AIDS in Rakai District, Uganda Dev. Pract. 1995 November; 5(4): 346-51.

23. Rutayuga JB. East Africa AIDS Orphans. AIDS Soc. July-August 1995; 6(4): 8.

24. Silomba. W. HIV/AIDS and Development. The Chikankata Experience (Sidastudies Number 7 One Step further- Responses to HIV/AIDS- Editor Anne Sisask. Elanders Novum AB, Gothenburg 2002: 77-89.

25. Unicef. HIV/AIDS in Eastern and Southern Africa; Caring for children Orphaned by HIV/AIDS. 2002.

26. Unicef, UNAIDS, Report on the Africa Leadership Consultation: Urgent Action for Children on the Brink, Johannesburg, 9-10 September 2002:2.

27. Unicef, Africa's orphaned generations November 2003; executive summary: 6-7.

28. United Nations Committee on the Rights of the Child 33rd session, 19 May -6 June 2003, CRC/C/15/Add.206.

29. UNAIDS, Mother to Child Transmission Technical Report, October 1998:6.

30. Wine, Michael, AIDS blamed for legions of orphans in Africa. New York Times 2003; 153(52680): A6.

31. Waddell Richard D. et al, Bacteraemia due to mycobacterium tuberculosis or M.bovis, Bacille Calmette-Guerin(BCG)among HIV-positive and adults in Zambia. Lippincott Williams & Wilkins AIDS 2001, 15:55-60.

Appendices

Appendix a: consent form

CARE OF ORPHANS IN TRADITIONAL FOSTER HOMES (EXTENDED FAMILY CARE) IN LUSAKA DISTRICT.

Consent form for the Head of household.

Age

Date

Place

Signature of or Thumbprint.

.....

CARE OF ORPHANS IN TRADITIONAL FOSTER HOMES (EXTENDED FAMILY CARE) IN LUSAKA DISTRICT.

Consent form for the non-consenting age given by the caretaker.

Signature of head of household

or Thumbprint.

.....

THE UNIVERSITY OF ZAMBIA

RESEARCH ETHICS COMMITTEE

Telephone: 256067
Telegrams: UNZA, LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260-1-250753
E-mail: unzarec@zamtel.zm

Dean's Office
P.O. Box 50110
Lusaka, Zambia

Assurance No. FWA00000338
IRB00001131 of IOR G0000774

Ref: 004-04-04
13 July, 2004

Dr Felix Silwimba, BSc HB, MBChB
Department of Community Medicine
P.O. Box 50110
LUSAKA

Dear Dr Silwimba,

RE: SUBMITTED RESEARCH PROPOSAL

The following research proposal was presented to the Research Ethics Committee Meeting on 28 April, 2004 where changes were recommended. We would like to acknowledge receipt of the corrected version. The proposal has now been approved. Congratulations!

Title of proposals: **'Care of orphans in traditional foster homes (extended family care) in Lusaka District'**

Conditions:

- This approval is based strictly on your submitted proposal. Should there be need for you to modify or change the study design or methodology, you will need to seek clearance from the Research Ethics Committee.
- If you have need for further clarification please consult this office. Please note that it is mandatory that you submit a detailed progress report of your study to this committee every six months and a final copy of your report at the end of the study.
- Any serious adverse events must be reported to the committee.

Yours sincerely

Prof. J. T. Karashani, MB, ChB, PhD
CHAIRMAN
RESEARCH ETHICS COMMITTEE

Date of approval: 13 July, 2004 Date of Expiry: 12 July, 2005

Please note that when your approval expires you may need to request for renewal. The request should be accompanied by a progress report (Progress Report Forms can be obtained from the Secretariat).

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE

Telephone: 252640
Telegram: UNZA, Lusaka
Telex: UNZALU ZA 44370
Fax: + 260-1-250783
Email: yfmulla@yahoo.com

Dean's Office
P.O. Box 50100
Lusaka, Zambia
Your Ref:

7th September, 2004

Dr. Felix Silwimba
Department of Community Medicine
School of Medicine

Dear Dr. Silwimba,

Re: MASTER OF PUBLIC HEALTH RESEARCH PROPOSAL

Your research proposal for the Master of Public Health entitled: **"Care of Orphans in Traditional Foster Homes (Extended Family Care) in Lusaka"** was presented at the Graduate Studies Committee of the School held on 5th August, 2004.

I am pleased to inform you that your proposal was approved by the Committee subject to corrections to see your Supervisor for further corrections. You can proceed to Part II of the programme and your Supervisor is Prof. K. S. Baboo and your Co-supervisor is Prof. S. Siziya.

I wish you every success in your studies.

Yours sincerely,

Professor Y. Mulla
ASSISTANT DEAN, POSTGRADUATE

c.c Director, Graduate Studies
Dean, School of Medicine
Head, Department of Community Medicine
Prof. S. K. Baboo, Department of Community Medicine
Prof. S. Siziya, Department of Community Medicine

Department of Community Medicine
School of Medicine
P.O. Box 50110
Lusaka.
Monday, 26 July 2004

The District Director of Health.
Lusaka District.
Lusaka.

UFS ; The Head.
Department of Community Medicine.
School of Medicine.
Lusaka.

HEAD COMMUNITY MEDICINE
SCHOOL OF MEDICINE
UNIVERSITY OF ZAMBIA
P.O. BOX 50110, LUSAKA.

Dear Sir,

Re: Permission to conduct research.

I hereby request for permission to conduct research in you district under the Kabwata health centre catchment area. The research title is 'Care of Orphans in traditional foster homes (extended family care) in Lusaka District'.

Successful completion of this study will enable me obtain my Masters Degree in Public Health.

Enclosed is a letter of approval from the University of Zambia Research Ethics Committee.

Yours sincerely

Dr Felix Silwimba.

MINISTRY OF HEALTH
LUSAKA DISTRICT HEALTH MANAGEMENT BOARD

20th July, 2004

The Health Centre In-Charge
Kabwata Health Centre
LUSAKA.

RE: PERMISSION TO CARRY OUT A RESEARCH

I write to inform you that permission has been granted for Dr. Felix Silwimba a Public Health student at University of Zambia to carry out research in the Health Centre catchment area.

However, this should be done with minimal disruption of the day to day activities of the institution.

Avail him your cooperation.

DR. M. KABASO
CLINICAL CARE EXPERT
FOR/DIRECTOR OF HEALTH-LDHMB

Information sheet.

CARE OF ORPHANS IN TRADITIONAL FOSTER HOMES (EXTENDED FAMILY CARE) IN LUSAKA DISTRICT.

Dear respondent.
This study is to find out to what extent do orphans and foster parents know and make use of services aimed at reducing the burden on families as a result of HIV/AIDS related orphanhood so as to strengthen already existing interventions community level to increase access to these services.
Some of the questions are as follows.

i. To see if you have any idea about the educational, health and psychological services available for orphans in the community.
ii. To see if you are aware of HIV/AIDS service providers who give care and support to orphans and foster parents.
iii. If these services exist an attempt will be made to know how many of you are making use of these services.
iv. Even if some of you know these services are available some of you still do not take advantage of them .we would want to know why you would not use these services.

Some of the questions will be sensitive if you do not feel like answering do not answer.
It is to inform you that whatever information will be collected from you will be kept with utmost confidentiality.
Your Participation in this study is voluntary, you have the right to refuse or withdraw from the study at any time you wish to.
This will not result in any penalty or loss of benefit to you, which otherwise you enjoy.
If you accept to participate in this study may you sign the concert form and respond to the interview.
If any problems following this research you should contact.

Dr Felix Silwimba.
C/O Department of Community Medicine
P.O. Box 50110
Lusaka.

Email silwimbaf@yaho .co.uk.
Cell Phone 097412840

Questionnaire for Head of household.

CARE OF ORPHANS IN TRADITIONAL FOSTER HOMES (EXTENDED FAMILY CARE) IN LUSAKA DISTRICT.

QUESTIONNAIRE ON ORPHANS.

1.Community_____

2. House Number_____

3.Head of Household No_____

4.Year of Birth _____

5.Age_____

6.Sex

M ☐ 1

F ☐ 2

7.Employment status An employer ☐ 1

An employee ☐ 2

Self - employed ☐ 3

An –Unpaid family Worker ☐ 4

Retired ☐ 5

8. What is your occupation?

9. What is your family Income?

10. Does your wife also contribute to family earnings? Yes No

.

11. If yes, what is her occupation?

12. What is her monthly income?

13. Total combined income of the family.

14. Any other source of income.

15. How much money is spent towards the welfare of orphans? (Give an estimate of the additional costs as a result of taking in orphans).

16. What are your responsibilities over the orphans?

Shelter ☐ Any other. ☐

Food ☐ Medication. ☐

Education ☐ All the above ☐

17. Marital status: Married ☐ Single ☐

Divorced ☐ Remarried ☐

18. If single are you? Unmarried ☐ Widow ☐ Widower ☐

19. Number of your own children. ☐

20.List of your own children. (living in the household now)

HHID	Sex	Year of birth	Age	Grade	Any Special needs

21.Do you take care of any orphans? Yes ☐ 1

No ☐ 2

22.If yes how many stay with you? ☐

23.List of orphans staying with you?

Child No	Sex	Year of birth	Age	Grade	Type 1=Double orphan. 2=loss of mother 3= loss of father.	Possible cause of death of parent (1=illness, 2=accident, 3=child birth related)

24. If illness is indicated in the last column in question 19, what was it?

HIV/AIDS ☐ Tuberculosis ☐

Chronic diarrhoea ☐ Long illness ☐

Malaria ☐ Meningitis ☐ Pneumonia ☐

Abortion ☐ after childbirth ☐

25.What type of support would you require to meet the costs of caring for your family and the orphans?

Material ☐ 1 None ☐ 4

Financial ☐ 2

Both ☐ 3

26.Are you aware of a government policy document on the protection of orphans and vulnerable children? Yes ☐ 1

No ☐ 2

27. If yes how has it been of help to you in taking care of the orphan?

28.Are you aware of a law in Zambia, which protects the rights of orphans and vulnerable children? Yes ☐ 1

No ☐ 2

29. If yes how has this affected you in the care of orphans?

30.Are you aware of government measures to alleviate hardships in families supporting orphans and other vulnerable children?

Yes ☐ 1

No ☐ 2

31. If yes how have you made use of these means by government to reduce the burden on the foster parents?

32.Are you aware of any services available for the psychosocial counselling of orphans?

Yes☐ 1

No ☐ 2

33. If yes have had an experience where you had to send an orphan under your care for psychosocial counselling?

34.Are you aware of a government bursary for the education of orphans?

Yes ☐ 1

No ☐ 2

30. If yes, do you have an orphan benefiting from the bursary scheme?

35.Are their any community-based programs in your area to address the needs of orphans and their foster families?

Yes☐ 1

No☐ 2

36.If yes, Would you mention the community-based organisation helping your family?

(Enter name of organisation, if none indicate none)

37. How have the community based support groups benefited you?

Improved care ☐

Budget relief. ☐

Support with education ☐

Support with health. ☐

38.If you are aware of the community based support groups, why aren't you making use of the community based support group?

Interfering in a personal matter. ☐

You are capable of caring for the orphans. ☐

The services are not as good. ☐

No reason. ☐

39. Do you think the number of orphans in the community/ family is increasing or decreasing?

Give reasons.

CARE OF ORPHANS IN TRADITIONAL FOSTER HOMES (EXTENDED FAMILY CARE) IN LUSAKA DISTRICT.

Consent form for the non consenting age given by the caretaker.

Signature of head of household ----------

or Thumbprint.

On behalf of ---------- (name of orphan).

Witness by Name _____ Signature _____

Questionnaire for the orphan.

CARE OF ORPHANS IN TRADITIONAL FOSTER HOMES (EXTENDED FAMILY CARE) IN LUSAKA DISTRICT.

QUESTIONNAIRE FOR ORPHANS CARE.

1.Head of Household ID ☐

2.Orphan ID ☐

3.Year of birth_____ 4.Age_____Sex

5.Are you going to school? Yes/ NO.

6. If yes which school do you go?

7. Preschool ☐ 1 Underage ☐ 5

Grade 1 to 7 ☐ 2

Grade 8 to 9 ☐ 3

Not in School ☐ 4

8. Have you changed schools Yes ☐ No. ☐

9.Has the change of school been from Private to Government schools? ☐

Or Government to Private School ☐

10.What was the reason for you to change the school?

11. What would you like to become after completing school?

12.How long have you been living with the present family?

13. After the death of your parents did you live with another family before joining this family?

14. Any reasons why you left the other family?

15. In which town or compound did you live before if any?

16.Relationship to Head of Household

Father ☐ 1

Mother ☐ 2

Brother ☐ 3

Sister ☐ 4

Uncle father's side ☐ 5

Aunt father's side ☐ 6

Uncle mother's side ☐ 7

Aunt mother's side ☐ 8

Cousin father's side ☐ 9

Cousin mother's side ☐ 10

Grandparents Father's side ☐ 11

Grandparents Mother's side ☐ 12

17.Type of orphan (*refer to the head of household questionnaire*)

Double 1 ☐

Single 2 ☐

18.If single orphan who is surviving.

Mother ☐ 1 father ☐ 2

19.Which community-based organisation is supporting you?

(Enter name of organisation, if none indicate none).

20.What is the area of support from the organisation /s above?

Education ☐ School Fees ☐ Health ☐

School Uniform ☐ School Books and Pencils, Pens ☐

Psychosocial and Care ☐

21. What is the source of water supply?

Tap in the house.

Borehole.

City council.

Well

Any other.

22. Excreta disposal.

Flush Latrine

Pit latrine.

Any other

23. Refuse disposal.

Bin.

Pit in the back yard.

Community disposal sit.

24. Light.

Electricity.

Kerosene lamp.

Any other

25. How many meals do have in a day?

26. Are the meals adequate?

What do you eat during?

Breakfast

Lunch

After school

Supper

27. How many Bedrooms have the house?

28. Do you have a bed to yourself? Or do you share?

29. What time do you go to school?

30. What time you return from the school?

31. How do you go to school?

Walk

Cycle.

Minibus.

32. Do you always require transport money to get to school and back everyday? Yes or No

33. Are you happy here? Yes or No

34. How is your health? Good/ ill health.

35. If ill health what has been the cause of your illness.

Cough

Fever

Loss of weight.

Rashes in the body

Diarrhoea.

36. When you fall sick who takes care of you.

37. Where do you go for treatment?

Hospital

Near by clinic

Traditional doctor

Treat at home.

Nothing is done.